Filing at a Glance

Company:	North American Company for Life and Health Insurance
Product Name:	Form 82-60, 82-61
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	11/13/2012
SERFF Tr Num:	NALH-128768456
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	FORM 82-60, 82-61
Implementation Date Requested:	01/01/2013
Author(s):	Sherry M. Olson
Reviewer(s):	Linda Bird (primary)
Disposition Date:	11/26/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *North American Company for Life and Health Insurance*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Form 82-60, 82-61*
Project Name/Number: *Form 82-60, 82-61/Form 82-60, 82-61*

General Information

Project Name: Form 82-60, 82-61
Project Number: Form 82-60, 82-61
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Sherry M. Olson

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: North American's domicile state of Iowa is a member of the Interstate Compact; these forms are being submitted to the Compact.

Market Type: Individual
Individual Market Type:
Filing Status Changed: 11/26/2012
State Status Changed: 11/26/2012
Created By: Sherry M. Olson
Corresponding Filing Tracking Number:

Filing Description:

RE: North American Company for Life and Health Insurance
NAIC # 66944 FEIN # 36-2428931
Form QX82-60 (10-12), Gliding, Hang Gliding and Ultralight Aircraft Questionnaire
Form QX82-61 (10-12), Mountaineering/Climbing Questionnaire

We are filing the above forms for review and approval. These are new forms that will not replace any previously approved forms. The forms are laser printed and we reserve the right to change logos, company address, fonts and layouts. We certify the font size will never be less than the minimum 10 point required.

These forms will be used as supplemental applications along with North American's approved life insurance applications forms. These application forms may be used to apply for current and future approved North American individual life insurance policy forms, including those available in the bank-, credit union- or corporate-owned life insurance market where they are designed for purchase in connection with non-qualified deferred compensation plans (employee compensation and benefit plans, key person insurance and insurance to cover the costs of providing pre- and post-retirement employee benefits). The employer/corporation is the owner, beneficiary and pays the premiums on policies covering employee/insureds.

For informational purposes, a Statement of Variability that provides the variable ranges and variable text for the bracketed information is attached to the Supporting Documents tab.

We reserve the right to have the forms completed electronically, including the use of electronic signatures, in compliance with the Uniform Electronic Transactions Act and/or the Federal ESIGN Act.

If you need any additional information to complete your review, please feel free to contact me at 800-283-5433, ext. 36223 or at solson@sfgmembers.com

Sincerely,

Sherry Olson
Senior Contract Analyst
Corporate Markets Center
Midland National Life Insurance Company &
North American Company for Life and Health Insurance

State: *Arkansas* **Filing Company:** *North American Company for Life and Health Insurance*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Form 82-60, 82-61*
Project Name/Number: *Form 82-60, 82-61/Form 82-60, 82-61*

Company and Contact

Filing Contact Information

Sherry Olson, Senior Contract Analyst
2000 44th St. South, Suite 300
Fargo, ND 58103

solson@mnlife.com
701-433-6223 [Phone]
701-433-8223 [FAX]

Filing Company Information

North American Company for Life and Health Insurance
Principal Office: 4601 Westown Parkway - Suite 300
West Des Moines, IA 50266
(800) 800-3656 ext. [Phone]

CoCode: 66974
Group Code: 431
Group Name:
FEIN Number: 36-2428931

State of Domicile: Iowa
Company Type: Life and Annuity
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50 per form x 2 forms
Per Company:	No

Company	Amount	Date Processed	Transaction #
North American Company for Life and Health Insurance	$100.00	11/13/2012	64842118

SERFF Tracking #:	*NALH-128768456*	***State Tracking #:***		***Company Tracking #:***	*FORM 82-60, 82-61*

State:	*Arkansas*	***Filing Company:***	*North American Company for Life and Health Insurance*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Form 82-60, 82-61*		
Project Name/Number:	*Form 82-60, 82-61/Form 82-60, 82-61*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/26/2012	11/26/2012

SERFF Tracking #:	*NALH-128768456*	***State Tracking #:***		***Company Tracking #:***	*FORM 82-60, 82-61*

State:	*Arkansas*	***Filing Company:***	*North American Company for Life and Health Insurance*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Form 82-60, 82-61*		
Project Name/Number:	*Form 82-60, 82-61/Form 82-60, 82-61*		

Disposition

Disposition Date: 11/26/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Gliding, Hang Gliding and Ultralight Aircraft Questionnaire		Yes
Form	Mountaineering/Climbing Questionnaire		Yes

SERFF Tracking #:	*NALH-128768456*	***State Tracking #:***		***Company Tracking #:***	*FORM 82-60, 82-61*

State:	*Arkansas*	***Filing Company:***	*North American Company for Life and Health Insurance*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Form 82-60, 82-61*		
Project Name/Number:	*Form 82-60, 82-61/Form 82-60, 82-61*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Gliding, Hang Gliding and Ultralight Aircraft Questionnaire	QX82-60 (10-12)	AEF	Initial		57.600	Form QX82-60.pdf
2		Mountaineering/Climbing Questionnaire	QX82-61 (10-12)	AEF	Initial		57.600	Form QX82-61.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

North American Company
for Life and Health Insurance
Since 1886

Gliding, Hang Gliding and Ultralight Aircraft Questionnaire

Name of Proposed Insured:	Date of Birth:

1. Do you participate in:
   Hang Gliding: Yes ☐ No Ultralight Aircraft: Yes ☐ No Gliding: Yes ☐ No
2. Are you a member of an Association or club related to this activity? Yes ☐ No
   If Yes, which ones? _____
3. How long have you been participating? _____ years. Total hours flown: _____
4. Any special licenses or certificates? Yes ☐ No If Yes, please list: _____
5. Are you a licensed pilot? Yes ☐ No Type (Private, Commercial, Student, Other): _____
6. Do you instruct and/or fly professionally? Yes ☐ No
7. Do you fly non-powered? Yes ☐ No Powered? Yes ☐ No If Yes, type: _____
8. Number of flights: Last 12 months: _____ 1-2 years ago: _____ Estimated next 12 months _____
9. What is the USUAL height: _____ (feet), distance _____ (miles) and duration _____ (hrs) which you have flown?
10. What is the GREATEST height: _____ (feet), distance _____ (miles) and duration _____ (hrs) which you have flown?
11. Have you, or do you intend any height, distance or duration records, or any stunts? Yes ☐ No
    If Yes, provide details: _____
12. Have you ever flown or within the next two years do you intend to fly:
    a. Experimental equipment? Yes ☐ No
    b. Any amateur-built/kit-built or antique/vintage aircraft? Yes ☐ No
    c. Total hours flown in aircraft listed in a and b: _____

I hereby agree that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at:	Date:
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each page.

NORTH AMERICAN COMPANY • [CORPORATE MARKETS CENTER: 2000 44TH STREET S., STE. 300, FARGO, ND 58103 • PRINCIPAL OFFICE: WEST DES MOINES, IA
Phone: (800) 283-5433 • Fax: (701) 433-8596 • www.sfgcorpmarkets.com]

North American Company
for Life and Health Insurance
Since 1886

Mountaineering/Climbing Questionnaire

Name of Proposed Insured:	Date of Birth:

1. Type(s) of Climbing: ☐ Trail ☐ Rock ☐ Snow & Ice ☐ Mountain
   Other (explain): _____
   Frequency of each: _____
2. Date and location of last climb? _____
3. How long have you been climbing? _____
4. What courses have you completed and in what year(s)? _____
5. Do you climb alone? Yes ☐ No ☐
   If No, how many other people are normally in your party? _____
   What would their climbing experience usually be? _____
6. Name where you have climbed over the past 3 years:

Geographical location	Type of Climbing	Altitude	Level (Yosemite Decimal System)

7. Time of year you climb: _____
8. List any equipment you normally carry: _____
9. On your average climb, how many hours/days would you be climbing? _____
   What are your average heights? _____
   What would be your level(s) of difficulty? _____
10. What was your highest climb, level and date? _____
11. What are your future climbing goals and climbing locations? _____
12. Additional comments: _____

I hereby agree that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. A copy of this form will be attached to and made a part of my application for insurance.

Signed at:	Date:
Witness:	Signature of Proposed Insured:

If more space is needed attach additional page, please sign and date each page.

NORTH AMERICAN COMPANY • [CORPORATE MARKETS CENTER: 2000 44TH STREET S., STE. 300, FARGO, ND 58103 • PRINCIPAL OFFICE: WEST DES MOINES, IA
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SERFF Tracking #:	*NALH-128768456*	***State Tracking #:***	***Company Tracking #:*** *FORM 82-60, 82-61*

State:	*Arkansas*	***Filing Company:***	*North American Company for Life and Health Insurance*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Form 82-60, 82-61*		
Project Name/Number:	*Form 82-60, 82-61/Form 82-60, 82-61*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:	Rule & Regulation 19 certification attached. Rule & Regulation 49 does not apply to application forms. Flesch Certification attached. Bulletin 15-2009 replaces Bulletin 11-88 and does not apply to application forms.		
Attachment(s):			
82-60, 82-61 _10-12_ readability.pdf 82-60, 82-61 _10-12_ AR Cert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application		
Comments:	These questionnaires may be used with Form 82-52 (10-12) and Form 82-47 (10-12), which were approved 11/9/12 (SERFF Tr#: NALH-128752337).		
Attachment(s):			
Form 82-52 _10-12_.pdf Form 82-47 _10-12_ rev 10-22-12.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
82-60, 82-61 Statement of Variability.pdf			

READABILITY CERTIFICATE

Name and Address of Insurer: North American Company for Life and Health Insurance
Corporate Markets Center
2000 44th Street South, Ste. 300 Fargo, ND 58103

I hereby certify that Readability has been tested under the Flesch Readability formula set forth by Rudolph Flesch in his book, The Art of Readability Writing and that the form(s) listed below meet your minimum readability requirements of your state.

FORM NUMBER	DESCRIPTION	SCORE
Form QX82-60 (10-12)	Gliding, Hang Gliding and Ultralight Aircraft Questionnaire	57.6
Form QX82-61 (10-12)	Mountaineering/Climbing Questionnaire	57.6

Carmen R. Walter

Signature

Carmen Walter
Typed Name

Assistant Vice President – Corporate Markets Product Development
Title

November 13, 2012
Date

TO: Arkansas Department of Insurance

FROM: North American Company for Life and Health Insurance

DATE: November 13, 2012

RE: Form QX82-60 (10-12), Gliding, Hang Gliding and Ultralight Aircraft Questionnaire
Form QX82-61 (10-12), Mountaineering/Climbing Questionnaire

Midland National Life Insurance Company certifies that the referenced forms comply with Arkansas Regulation 19 § 10B regarding unfair sex discrimination in insurance.

Carmen R. Walter

Carmen R. Walter
Assistant Vice President – Corporate Markets Product Development
Corporate Markets
North American Company for Life and Health Insurance

Date: November 13, 2012

North American Company
for Life and Health Insurance
Since 1886

Regular Issue
Application for Life Insurance -- Part 1

1. Name of Proposed Insured (First, Middle and Last)	Birth date	Birthplace	Sex	Marital Status

2. Residence Address (Street, City, State, Zip)	Social Security No.	Height	Weight
		ft. in.	Lbs.

2a. Secondary Addressee (Name, Street, City, State, Zip)

3. Occupation (Title and Duties) Gross Annual Compensation $	Telephone Numbers (Home) (Bus)

4. Owner Name (If Trust, Name and Date of Trust)	Social Security or Tax ID No.

Owner Address (Street, City, State, Zip)	Relationship to proposed Insured

5a. Beneficiary	5b. Relationship

6a. Plan Applied for (Name of Product)	6b. Sub-account (If Applicable)

6c. Amount Applied for $	6d. Death Benefit Option: ❒ 1 Level ❒ 2 Increasing ❒ Other _____
7. Changes to existing North American policy #: _____ . Describe:	8. Additional Benefits:
9a. Premium $	9b. Premium Mode ❒ Single ❒ Annual ❒ Other

10. Are you a U.S. citizen? ❒ Yes ❒ No **(complete appropriate questionnaire)**

11a. Do you have existing annuity contracts or life insurance policies? ❒ No ❒ Yes **(If "Yes," complete 11b.)**

11b. Policies in Force:

Company	Face Amount	Indicate Personal	Indicate Business	Intention of Replacement or Change	
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No
		❒	❒	❒ Yes	❒ No

11c. Policies Applied for / Indicate Below or ❒ None:

Company	Amount	Net Amount at Risk	Indicate Personal	Indicate Business
			❒	❒
			❒	❒
			❒	❒
			❒	❒

NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE
[PRINCIPAL OFFICE • WEST DES MOINES, IA 50266
CORPORATE MARKETS CENTER • 2000 44TH STREET SOUTH, STE. 300 • FARGO, ND 58103
PHONE (800) 283-5433 • FAX: (701) 433-8596]

Provide details for all "Yes" answers to questions 12-20 below.

Yes	No		Yes	No	
		12. Have you ever used:	❒	❒	16. Are you currently a pilot, student pilot or crew member in any type of aircraft or within the next two years do you intend to become a pilot, student pilot, or crew member in any type of aircraft? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	a) Cigarettes? Date last used: _____	❒	❒	17. Except for traffic violations, have you ever pled guilty to or been convicted of a felony or misdemeanor?
❒	❒	b) Other nicotine products? Date last used: _____	❒	❒	18. Within the past five years, have you been convicted of or pled guilty to any moving violations?
❒	❒	13. Have you ever had an application for insurance declined, postponed or rated?	❒	❒	19. Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?
❒	❒	14. Do you intend to travel outside the U.S. or Canada within the next 2 years? **(If "Yes", complete appropriate questionnaire.)**	❒	❒	20. Your driver's license #: _____ State: _____
❒	❒	15. Do you currently engage in or within the next two years do you intend to engage in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? **(If "Yes", complete appropriate questionnaire.)**			

Details for questions 12-20 (include dates):

Question Number	Date	Details

21. ❒ Yes ❒ No Do your parents or siblings have a history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease, or any congenital disorder? If "Yes," give details, including relationship, condition, current age, or age at death.

Relationship to Proposed Insured	Condition	Current Age	Age at Death

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated, diagnosed or been given advice by a medical professional for:

Yes	No	
❒	❒	a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?
❒	❒	b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?
❒	❒	c. Cancer, tumor, polyp or blood disease or disorder?
❒	❒	d. Immune system disease or disorder, except those related to the Human Immunodeficiency Virus (AIDS virus)?
❒	❒	e. Diabetes, kidney, or urinary disease or disorder?
❒	❒	f. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?
❒	❒	g. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?
❒	❒	h. Depression, mental illness, anxiety or seizure disorder?
❒	❒	i. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?
❒	❒	j. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?

3. Excluding minor illnesses or minor injuries not requiring treatment, other than above, have you ever:

❒	❒	a. Within the last five years, consulted any other physician or medical practitioner, or had a diagnostic test, such as an electrocardiogram (EKG), chest X-ray, laboratory test or other study?
❒	❒	b. Within the last five years, received medical treatment or advice, including medication, or been hospitalized or had surgery?
❒	❒	c. Within the last five years, applied for, or received benefits, because of injury, accident, sickness, or disability?
❒	❒	d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?
❒	❒	e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4. Have you ever:

❒	❒	Been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are to the best of their knowledge and belief, true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and North American Company for Life and Health Insurance's (the "Company") only liability shall be to refund any advance payment made.

The Company will have no liability unless: (a) the application is approved; (b) the first full premium is paid; and (c) the policy is issued and the Owner accepts it. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in the application. If these requirements are met, insurance will be in effect on the policy effective date. By accepting the policy, the Owner consents to any changes or corrections made by the Company, except that changes in the insurance amount, the risk class, the insurance plan, gender or benefits will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize North American, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation. I understand that no sales representative has the Company's authorization to accept risk, pass on insurability, or make or void, save or change any conditions or provisions of the application, policy or receipt, as applicable.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorized individuals are signing on behalf of the entity purchasing the life insurance and each individual is authorized and empowered to individually or collectively enter into contracts and financial transactions including the purchase of life insurance. The entity is duly organized and existing in compliance with all laws and regulations. The entity shall notify the Company in writing of a change in or revocation of authorized individuals. The authorized individuals and the entity agree to indemnify the Company for liability of any kind arising out of any acts or omissions taken by the Company upon their instructions and in reliance on their representations to the Company in connection with the policy.

_____ Signed at _____

Signature of Proposed Insured *Date* *City* *State*

_____ _____

Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.) *Date*

Agent certification

(1)To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; and (3) to the best of my knowledge and belief, the applicant ❒ **does** ❒ **does not** have any existing life insurance or annuities; and the insurance applied for ❒ **does** ❒ **does not** replace existing insurance.

_____ _____ _____

Signature of Agent *Date* *Agent's No.*

North American Company
for Life and Health Insurance
Since 1886

Application for Policy Reinstatement or Change

1. Name of Insured (First, Middle and Last)	Birth date	Birthplace	Sex	Marital Status

2. Residence Address (Street, City, State, Zip)	Social Security No.	Height ft. in.	Weight lbs.

3. Policy Number	4. Occupation / Title and Gross Annual Compensation $	Telephone # (home): (business):

5a. Owner Name and Address	5b. Social Security or Tax ID No.
	5c. Relationship to Proposed Insured

6. Policy Change requested:

❒ Reconsideration of Rate Class ❒ Reinstatement

❒ Other: _____

7. Life Insurance and annuities in force and pending: If None, check here: ❒

Company	Policy #	Personal or Business	Pending	Issue Year	Benefit Amount	ADB Amount	WP Amount	Intention of Replacement or Change
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N
			❒					❒ Y ❒ N

Provide details for all "Yes" answers to questions 8-18 below.

Yes	No		
❒	❒	8.	Are you a U.S. citizen? **(If "No", complete appropriate questionnaire.)**
		9.	Have you ever used:
❒	❒		a) Cigarettes? Date last used: _____
❒	❒		b) Other nicotine products? Date last used: _____
❒	❒	10.	Have you ever had an application for insurance declined, postponed or rated?
❒	❒	11.	Do you intend to travel outside the U.S. or Canada within the next 2 years? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	12.	Do you currently engage in or within the next two years do you intend to engage in aviation related sports, powered or competitive vehicle racing, sky or scuba diving, mountain climbing, or any other hazardous sport or activity? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	13.	Are you currently a pilot, student pilot or crew member in any type of aircraft or within the next two years do you intend to become a pilot, student pilot, or crew member in any type of aircraft? **(If "Yes", complete appropriate questionnaire.)**
❒	❒	14.	Except for traffic violations, have you ever pled guilty to or been convicted of a felony or misdemeanor?
❒	❒	15.	Within the past five years, have you been convicted of or pled guilty to any moving violations?
❒	❒	16.	Have you ever pled guilty to or been convicted of driving while under the influence of alcohol or drugs?
❒	❒	17.	Your driver's license #: _____ State: _____
❒	❒	18.	Do your parents or siblings have a history of heart disease, cancer, high blood pressure, diabetes, hemophilia, Huntington's chorea, polycystic kidney disease, or any congenital disorder?

Details for questions 8-18:

1a. Name and address of Personal Physician:

1b. Date and reason last consulted:

1c. Name and Address of physician **most recently** consulted if different than above:

1d. Date and reason for most recent consultation:

1e. List any currently prescribed medications:

2. Have you ever had or been treated, diagnosed or been given advice by a medical professional for:

Yes	No	
❒	❒	a. Elevated cholesterol, high blood pressure, transient ischemic attack (TIA), stroke or circulation disorder?
❒	❒	b. Chest pain, heart attack, heart murmur, irregular heart rate, or other disease or disorder of the heart?
❒	❒	c. Cancer, tumor, polyp or blood disease or disorder?
❒	❒	d. Immune system disease or disorder, except those related to the Human Immunodeficiency Virus (AIDS virus)?
❒	❒	e. Diabetes, kidney, or urinary disease or disorder?
❒	❒	f. Crohn's disease, colitis, ulcer, diverticulitis, hepatitis, or any disease of the esophagus or liver?
❒	❒	g. Sleep apnea, asthma, emphysema, lung or respiratory disease or disorder?
❒	❒	h. Depression, mental illness, anxiety or seizure disorder?
❒	❒	i. Breast, uterus, ovaries, testicles or prostate disease or disorder, or sexually transmitted diseases?
❒	❒	j. Arthritis, lupus, fibromyalgia or other skin, bone, joint or muscle disease or disorder?

3. Excluding minor illnesses and minor injuries not requiring treatment, other than above, have you ever:

❒	❒	a. Within the last five years, consulted any other physician or medical practitioner, or had a diagnostic test, such as an electrocardiogram (EKG), chest X-ray, laboratory test or other study?
❒	❒	b. Within the last five years, received medical treatment or advice, including medication, or been hospitalized or had surgery?
❒	❒	c. Within the last five years, applied for, or received benefits, because of injury, accident, sickness, or disability?
❒	❒	d. Sought or received treatment for, or been arrested for, the use of alcohol, marijuana, or drugs?
❒	❒	e. Used narcotics, cocaine, LSD, marijuana, amphetamines, or barbiturates, unless administered on the advice of a physician?

4.Have you ever:

❒	❒	Been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?

5. Details for questions 2-4. Give details for each YES answer.

Question Number	Condition/Diagnosis	Approximate Dates/Duration	Treatment	Physician Name & Address

Agreement and Authorization

Each person who signs below represents and agrees that the statements and answers recorded on this application are given to obtain this insurance and are to the best of their knowledge and belief, true, complete, and correctly recorded. Fraud or material misrepresentation in the application will make this agreement invalid, and North American Company for Life and Health Insurance's (the "Company") only liability shall be to refund any advance payment made.

It is agreed that the Policy will not be reinstated or a change will not be effected, and the Company will have no liability until: (a) this application is approved; and (b) all money required for reinstatement and/or change has been paid. This must be during the lifetime of any person proposed for insurance; also, his or her eligibility and health must remain as described in this application. If these requirements are met, insurance will be in effect on the effective date of the reinstatement or change. By accepting the reinstated policy or changed policy, the Owner consents to any changes or corrections made by the Company, except that changes in the insurance amount, the risk class, the insurance plan, gender or benefits will be made only with the Owner's written consent. Each person who signs below acknowledges that he or she has read and understands this application and has received copies of the Fair Credit Reporting Act Notification, Notice of Insurance Information Practices, and the Medical Information Bureau Notification.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc (MIB), consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me and any information as to employment, other insurance coverage, or other non-medical information about me to give to the Company or its reinsurers, any and all such information. I authorize North American, or its reinsurers, to make a brief report of my personal health information to MIB. I authorize all of these sources, except MIB, to give records or knowledge to any agency that the Company employs to collect and transmit such information. The Company will not release any information to any person or organization **except** to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may authorize later. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. I understand that I am entitled to receive a copy of the investigative consumer report upon request. I understand that I may request a copy of this authorization and that a photographic copy will be as valid as the original, and either shall remain in effect for a period of two years from the date signed. I have the right to revoke this authorization by notifying the Company in writing. The Company may rely on my authorization prior to receiving my notice of revocation. I understand that no sales representative has the Company's authority to accept risk, pass on insurability, or make or void, save or change any conditions or provisions of the application, policy or receipt, as applicable.

Insurance products and annuities are not a deposit or other obligation of, or guaranteed by a bank, any affiliate of a bank, or savings association, and are not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, a bank, any affiliate of a bank, or savings association, and involve investment risk, including possible loss of value. The approval or disapproval of any extension of credit by the bank or an affiliate is not based on whether or not this insurance is purchased through the bank or through any particular source.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and I am not subject to back up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

FRAUD STATEMENT – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorized individuals are signing on behalf of the entity purchasing the life insurance and each individual is authorized and empowered to individually or collectively enter into contracts and financial transactions including the purchase of life insurance. The entity is duly organized and existing in compliance with all laws and regulations. The entity shall notify the Company in writing of a change in or revocation of authorized individuals. The authorized individuals and the entity agree to indemnify the Company for liability of any kind arising out of any acts or omissions taken by the Company upon their instructions and in reliance on their representations to the Company in connection with the policy.

Signed at _____ Date _____
City *State*

_____
Signature of Proposed Insured

_____
Signature of Owner (If Owner is corporation, trust or other entity, include title of signee.)

Agent certification

(1)To the best of my knowledge and belief, the answers given to the questions in this application are full, complete, and true, and there is nothing adversely affecting the insurability of any person proposed for insurance, except as stated in this application; (2) that I gave the Medical Information Bureau Notification, Notice of Insurance Information Practices and Fair Credit Reporting Act Notification to the Proposed Insured; (3) to the best of my knowledge and belief, the applicant ❒ **does** ❒ **does not** have any existing life insurance or annuities; and, the insurance applied for ❒ **does** ❒ **does not** replace existing insurance.

_____ _____ _____
Signature of Agent *Date* *Agent's No.*

STATEMENT OF VARIABILITY
Application Form Series Form QX82-60, Form QX82-61

The following is a list of bracketed items and the corresponding range of text and/or values.

Bracketed Item	Variable Text/Range
Logo, Principal Office location and Corporate Markets Center Office location and contact information	Have been bracketed to reserve the right to change or delete addresses and contact information without re-filing this application for approval. Any change to the Company logo will be filed on an informational basis.